1 Month Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Medications:	Birth wt:	Wt:	%	Length:	%	Head circ:	%

Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown
Second Newborn Hearing Screen (if 2nd needed/completed): ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown

PARENTAL CONCERNS/HISTORY: How are you feeling about the baby? Do you feel safe in your home?

NUTRITIONAL SCREEN: [X] **INDICATES GUIDANCE GIVEN:** ☐ Breast fed ☐ Formula: _____ ☐ Cereal ☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] **INDICATES ACCOMPLISHMENT:** ☐ Responds to sounds ☐ Responds to parent's voice ☐ Follows with eyes ☐ Awake for 1 hour stretches ☐ Beginning Tummy Time Play ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] **INDICATES GUIDANCE GIVEN:** ☐ Supine sleep ☐ Car seat/rear facing ☐ Infant bonding ☐ Bottle prop☐ Support/who can help? ☐ Infant crying/what to do? ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Passive smoke ☐ Emergency/911 ☐ Sun safety ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] **INDICATES OBSERVED BY CLINICIAN/PARENT REPORT:** ☐ Family Adjustment/parent responds positively to child ☐ Length of time infant cries ☐ Infant hands to mouth/self calming ☐ Encourage holding ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED:	[X] **INDICATES ORDERED** ☐ 2nd Newborn screening **(5 – 10 days of age or first PCP visit)** ☐ Other
IMMUNIZATIONS:	[X] **INDICATES ORDERED** ☐ 1st Hepatitis B vaccine date: _____ ☐ Pt. Needs immunization today ☐ Shot record initiated ☐ 2nd Hepatitis B vaccine date: _____ ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason
REFERRALS:	[X] **INDICATES REFERRED** ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ 2nd Newborn hearing screen **(if needed)** ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

Revised November 1, 2007